foundcare
your community health center

REGISTRATION FORM

Patient Information	***Emergency Contact Information***
First Name:	Emergency Contact Name:
Middle Name:	Relationship to Patient:
Last Name:	Address:
Social Security #:	City, State, ZIP:
Birth Date: MM DD YYYY	Reliable Phone Number:
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced	Second Emergency Contact:
	Reliable Phone Number:
Mailing Address:	***Parent/Guardian Information (if patient is under 18)***
City, State, ZIP:	Parent/Guardian Name:
Home Phone #:	Relationship to Patient:
Cell Phone #:	Parent/Guardian Birth Date:
Gender: ☐ Male ☐ Female Transgender: ☐ MtF ☐ FtM	Parent/Guardian Social Security #:
Language: ☐ English ☐ Spanish ☐ Creole ☐ Other:	Address:
Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African-American ☐ American Indian/Alaska Native ☐ White/Caucasian ☐ More than one race ☐ Other	City, State, ZIP:
	Reliable Phone Number:
*E-mail Address:	***Assignment/Acknowledgement***
How did you hear about us? ☐TV ☐ Internet ☐ Newspaper ☐ Brochure ☐ Family/Friend ☐ Other:	By my signature below, I hereby authorize FoundCare Health Center to release any information necessary to process any claim for health insurance payment. I request that any money due me for medical benefits be assigned to FoundCare, Inc., and I realize that I am responsible for any and all differences. I have received the documents indicated below and agree to their respective terms and conditions. I agree to pay all fees at the time of service or according to an agreed payment plan. I grant permission for third party auditors to view protected health information as a part of evaluation processes. All information on this form is truthful to the best of my knowledge and if there are changes to my income, insurance status, or other information, I agree to inform FoundCare Health Center.
*Preferred Pharmacy:	
*Preferred Pharmacy Phone:	
Check all that apply: ☐ Veteran ☐ Homeless ☐ Migrant/Seasonal Agricultural Worker	
Insurance Information	
Do you want to apply for sliding fee discounts? ☐ Yes ☐ No	
Household income: $ ☐ Weekly ☐ Monthly ☐ Yearly	
Number of people in household:	
Do you have health insurance? ☐ Yes ☐ No	*General Consent:* ☐
Insurance Company:	*Notice of Privacy Practices:* ☐
Effective Date:	*Patient Rights & Responsibilities:* ☐
Insured Person's Birth Date:	*Sliding Fee Scale Worksheet:* ☐
Policy Group Number:	***Signature***
Policy ID Number:	Patient/Guardian Signature:
Patient Relationship to Insured Person:	Date:
Secondary Insurance:	Witness: